KATHMANDU UNIVERSITY
SCHOOL OF MEDICAL SCIENCES,DHULIKHEL
STUDENTS' MEDICAL INSURANCE FORM

Full Name:……..……...Nationality:……..

Gender:…….DOB:…….... A.D.……B.S.

Email ID:…… Contact Number:……..

Program:……. Admission Year……..

Detail Address

District……. State/ Province……

Ward No……Municipality / VDC…….

Permanent Address:……

For Official Purpose Only

MI Insurance Number …… Date of Expiry:…….

…… ……

Applicant Signature Registration Department

KUSMS Dhulikhel Hospital